Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

TRUST BOARD
16th December 2010

TITLE	**Corporate Risk Register**
EXECUTIVE SUMMARY	This report presents the Corporate Risk Register as at 2nd December 2010, and highlights: • 1 New Risk pertaining to failure to act on radiological risk reports is being considered at TEC on the 10th December 2010 • 4 Existing Risks where the risk level has changed since 14th October 2010 • 0 Risks with a changed treatment plan since 14th Oct 2010 • 1 Risk closed since 14th October 2010 This report now includes a Target Risk Score should all the mitigating actions be successfully achieved.
ASSURANCE (Risk) / IMPLICATIONS	The Corporate Risk Register report provides assurance that relevant risks have been identified as corporate risks and by doing so there are action plans in place to mitigate the risk. The report contains summary information, the full Corporate Risk Register, as well as details of those risks closed in the period.
STAKEHOLDER / PATIENT IMPACT AND VIEWS	Not assessed and views not taken
EQUALITY AND DIVERSITY ISSUES	None identified
LEGAL ISSUES	The Corporate Risk Register is required by the Department of Health and is a particular requirement of the NHS Litigation Authority, as well as ALE. It is a fundamental requirement of Monitor when the Trust becomes a Foundation Trust.
The Trust Board is asked to:	The Trust Board is asked to note the contents of the Corporate Risk Register.
Submitted by:	Marty Williams, Clinical Risk Manager On behalf of, Susan Osborne, Interim Chief Nurse
Date:	16th December 2010
Decision:	For Noting

Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

TRUST BOARD
16th December 2010

Corporate Risk Register

Process

All risks submitted for inclusion on the Corporate Register must have a completed Trust Risk Register Notification Form. In the first instance the Manager of the area where the risk has been identified is to discuss the risk with, the appropriate Lead Executive Director.

If, in the view of the Lead Executive Director, the Trust Risk Register Notification Form contains all relevant information, and is an appropriate entry for the Corporate Risk Register the risk will be entered onto the Corporate Risk Register.

On a monthly basis, at the Trust Executive Committee meetings, all new risks entered on the Corporate Risk Register will be highlighted and discussed. The Corporate Risk Register last went to the Trust Executive Committee meeting on 26th November 2010

New Risks added since 14th October 2010

None

Existing Risks where the risk level has changed since 14th October 2010

ID	Title	Description	Reason	Previous level	Current level	Responsibility Owners
763	Health Care Acquired Infection & National Targets. (BAF 1.2)	There is a potential for failure to control Health Care Acquired Infection and not achieving the National (& SHA set) Target reductions. risk to patients and Trust reputation	***All previous updates can be accessed from paperwork held in the Quality department.*** Aug 10: A further MRSA case has been notified resulting in reaching the target for the whole year. Risk raised from High to Extreme. Oct 10: Dedicated phlebotomy team /CSNPs for taking blood cultures when required continues (Excluding NICU, Paeds, ITU). Only in extreme clinical situations and where the clinician is competent is this an exception. CVC line monitoring and VIP scoring for peripheral line MRSA screening for all emergency admissions. Competencies being rolled out Trustwide in regards to aseptic technique. **Nov 10: No MRSA bacteraemia since 29th July 10. Likelihood reduced to 3 resulting in a risk level of High from the previous Extreme.**	EXTREME	HIGH	Executive Director: Susan Osborne Lead Manager: Linda Fairhead
764	Delivery on all Performance Targets. (BAF 1.1 & 1.2)	Potential failure to deliver on some performance targets - In particular admitted pathway 90% target for some elective specialties (orthopaedics, oral surgery) and sustaining (ASPH alone) 98% '4 hour' target.	***All previous progress held on paper by the Quality Department - Risk Register section*** **Dec 10: Continued focus on key actions through daily capacity meetings and weekly review of key work plans and objectives on discharge and length of stay. A review of the present situation has resulted in the risk being raised from Medium to High.**	MEDIUM	HIGH	Executive Director: Valerie Howell Lead Manager: Valerie Howell

988	VTE phrophylaxsis assessment shortfall	The Trust is expected to demonstrate a 100% compliance with Venous Thromboembolism (VTE) [blood clot] risk assessment by April 2010. Currently (25/02/10) the Trust is achieving 61%. This will be a nationally and locally scrutinised target. Risk to patient safety, financial loss and reputation.	***All previous progress held on paper by the Quality Department - Risk Register section*** Aug 10: Trust compliance now at 75% which has allowed a reduction in the likelihood to 1. This gives a medium risk. **Nov 10: Trust now compliant at 90%. SHA has identified ASPH as an exemplar site. RCA for all admissions with PE and DUT now in place. Monthly audits of VTE assessment quality to be commenced December 2010. Risk reduced from medium to low.**	MEDIUM	LOW	Executive Director: Mike Baxter Lead Manager: Mike Baxter
1083	Corporate lack of Trust Social Services worker post	Currently there is no designated social services worker to lead on safeguarding children by the local authority. The risk is that vulnerable children could be missed or become unsupported by the lack of continuity of a designated social worker identified for the Trust. This risk applies to wherever children are cared for within the Trust, specifically Paediatric A&E, Paediatric wards and Paediatric Outpatients. Risk to patients, service, reputation and failure of statutory duty.	**Nov 10: Mitigation arrangements put in place including strengthening of link Social services worker, now confirmed as from Assessment Team. Strategy meetings to take place on SPH site where child is an inpatient. Ongoing monitoring of the situation ie low threshold for reporting of adverse incident which occur as a result of the lack of SW. Risk reduced from High to Medium (MH)**	HIGH	MED	Executive Director: Susan Osborne Lead: Helen Sibley, Nikki Love, Dr Kate BrocklesbyContact: Michael Hooker

Risk with a changed treatment plan since 14th October 2010

None

Risk closed since 14th October 2010

ID	Title	Description	Risk level	Opened	Closed date	Reason
848	Financial loss due to uninsured claims	Uninsured losses in excess of £100,000, particularly associated with claims preceding NHSLA insurance arrangements.	HIGH	20-May-2009	25-Nov-2010	***Previous progress held on paper by the Quality Department - Risk Register section.*** Oct 10: Our solicitors have requested details from us of the transfer documentation setting up the Trust in 1992 and 1998 as these may clarify precisely where the liability lies. **Nov 10: Liability for staff who did not transfer to the 1992 Trusts remains with the Strategic Health Authority therefore the Trust's exposure is greatly reduced. Risk closed.**

Summary of Corporate Risks as at 2nd December 2010

ID	Title	Risk level	Rating	Present Treatment	Opened	Review date	Responsibility Owners
Treat: Take actions to reduce or mitigate the risk							
806	Out of date Trust policies - Risk to patient & staff safety, and ineffective working.	HIGH	12	TREAT	27-Oct-2008	2-Feb-2011	Executive Director: Susan Osborne Lead Manager: Sarah Johnston
763	Health Care Acquired Infection & National Targets. (BAF 1.2)	HIGH	12	TREAT	12-Mar-2008	2-Jan-2011	Executive Director: Susan Osborne Lead Manager: Linda Fairhead
764	Delivery on all Performance Targets. (BAF 1.1 & 1.2)	HIGH	12	TREAT	12-Mar-2008	2-Feb-2011	Executive Director: Valerie Howell Lead Manager: Valerie Howell
1024	Loss of income due to application of 'non elective cap'	HIGH	12	TREAT	23-Jun-2010	2-Feb-2011	Executive Director: Valerie Howell Lead Manager: Karen Lillington
1088	Possible non-compliance with IG Toolkit submission and achievement of Level 2 on all requirements	HIGH	12	TREAT	12-Oct-2010	5-Jan-2011	Executive Director: John Headley Lead Manager: Tracy Street
1089	Lack of outpatients receptionist staff in the Trust.	HIGH	12	TREAT	12-Oct-2010	2-Feb-2011	Executive Director: Valerie Howell Lead manager: Hannah Donoghue
1072	Discharge process has identified risks to vulnerable patients	HIGH	9	TREAT	2-Sep-2010	3-Jan-2011	Executive Lead: Susan Osborne Lead Manager: Vanessa Avlonitis
768	Staff recruitment and retention. (BAF 2.2)	HIGH	9	TREAT	12-Mar-2008	2-Feb-2011	Executive Director: Raj Bhamber Lead Manager: Jeremy Over
832	Loss of income-Contracts. (BAF 3.4)	HIGH	8	TREAT	26-Mar-2009	5-Jan-2011	Executive Director: John Headley Lead Manager: Sue Robertson
847	Under delivery of CIP programme. (BAF 4.4) - Financial risk	HIGH	8	TREAT	20-May-2009	2-Feb-2011	Executive Director: John Headley Lead Manager: Rob Jeffries
837	Delay in Psychiatric assessment - A & E and MAU	MED	6	TREAT	9-Apr-2009	2-Mar-2011	Executive Director: Valerie Howell Lead Manager: Pat Rubin
833	Loss of private service provider	MED	6	TREAT	26-Mar-2009	2-Jan-2011	Executive Director: Valerie Howell Lead Manager: Karen Lillington
1037	Failure to monitor and review compliance with CQC regulations.	MED	6	TREAT	16-Jul-2010	2-Jan-2011	Executive Director: Lead Manager: Sarah Johnston
1057	Possible loss of patient confidence in the Complaints service.	MED	6	TREAT	12-Aug-2010	8-Mar-2011	Executive Director: Susan Osborne Lead Manager: Jill Down
1083	Corporate lack of Trust Social Services worker post	MED	6	TREAT	21-Sep-2010	2-Jan-2011	Executive Director: Susan Osborne Lead: Helen Sibley, Michael Hooker
769	Disproportionate focus on post Foundation Trust authorisation tasks.	MED	4	TREAT	12-Mar-2008	5-Mar-2011	Executive Director: Raj Bhamber Lead Manager: Vicki Hart-Dale

Summary of Corporate Risks as at 2nd December 2010

ID	Title	Risk level	Rating	Present Treatment	Opened	Review date	Responsibility Owners
766	Patient satisfaction scores. (BAF 1.7)	MED	4	TREAT	12-Mar-2008	2-May-2011	Executive Director: Susan Osborne Lead Manager: Vanessa Avlonitis
767	Privacy and Dignity issues for service users. (BAF 1.8)	LOW	3	TREAT	12-Mar-2008	2-May-2011	Executive Directors: Susan Osborne Lead Manager: Vanessa Avlonitis
988	VTE phrophylaxsis assessment shortfall	LOW	2	TREAT	25-Feb-2010	5-Mar-2011	Executive Director: Mike Baxter Lead Manager: Mike Baxter
Tolerate: Accept the risk at its current level of risk.							
1070	NHS funded healthcare team not completing patient assessments in the Trust which is impacting on capacity.	MED	6	TOL	31-Aug-2010	2-Jan-2011	Executive Director: Valerie Howell Lead Manager: Claire O'Brien

Corporate Risk Register as at 2nd December 2010

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
Treat: Take actions to reduce or mitigate the risk.											
806	Out of date Trust policies - Risk to patient & staff safety, and ineffective working.	The Trust policy database has only 13% of its policies in date. (October 08) Risk to patients, staff and service. Risk of not meeting the requirements of NHSLA risk management standards.	12	HIGH	27-Oct-2008	2-Feb-2011	***All previous action plans held on paper by the Quality department - Risk Register section.*** Oct 10: Facilities and estates to set up an action plan for review of policies in their area. **Dec 10: Senior managers for areas have been informed of current position and requirement to have all policies up to date by end of December. Dates for completion have been requested. The importance of policies has been highlighted by CQC reviews and this has been fed back to standard leads and review of standards requested to reflect this.**	***All previous updates held on paper in the Quality department - Risk Register section.*** Oct 10: Plan recommends completion of overdue policies by December 2010. **Dec 10: 57% of policies are in date or are known to be completed and are awaiting ratification or to be placed on the intranet. Nursing policies are in progress but no new policies completed at end of November. Facilities still to be completed. The majority of Information policies are out of date including information governance policy which poses a significant risk, this has been fed back to DMJ. HR policies being completed and on track in line with plan. Risk policies awaiting ratification at safety and risk committee 6th Nov. Risk score back up to 12 following CQC reviews of other Trusts which reflects a higher risk of failure to comply without policies in place.**	4	LOW	Executive Director: Susan Osborne Lead Manager: Sarah Johnston
763	Health Care Acquired Infection & National Targets. (BAF 1.2)	There is a potential for failure to control Health Care Acquired Infection and not achieving the National (& SHA set) Target reductions. risk to patients and Trust reputation	12	HIGH	12-Mar-2008	2-Jan-2011	***All previous action plans can be accessed from paperwork held in the Quality department.*** Aug 10: Trust wide MRSA action plan updated 9th August and local blood culture action plan formulated following the five MRSA bacteraemias Root Cause Analysis. Details held with paper copy update.	***All previous updates can be accessed from paperwork held in the Quality department.*** Oct 10: Dedicated phlebotomy team /CSNP's for taking blood cultures when required continues (Excluding NICU, Paeds, ITU). Only in extreme clinical situations and where the clinician is competent is this an exception. CVC line monitoring and VIP scoring for peripheral line MRSA screening for all emergency admissions. Competencies being rolled out Trustwide in regards to aseptic technique. **Nov 10: No MRSA bacteraemia since 29th July 10. Likelihood reduced to 3 resulting in a risk level of High from the previous Extreme.**	3	LOW	Executive Director: Susan Osborne Lead Manager: Linda Fairhead

Corporate Risk Register as at 2nd December 2010

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
764	Delivery on all Performance Targets. (BAF 1.1 & 1.2)	Potential failure to deliver on some performance targets - In particular admitted pathway 90% target for some elective specialties (orthopaedics, oral surgery) and sustaining (ASPH alone) 98% '4 hour' target.	12	HIGH	12-Mar-2008	2-Feb-2011	***All previous action plans held on paper by the Quality department - Risk Register section.*** Feb 10: Closer working between patient pathway team and directorate to improve performance in orthopaedics and improve booking practice. Some outsourcing of work. Recovery plan in terms of four hour target focused on medical staffing at peak times and improved management capacity. **Dec 10: Increased focus on all aspects of patient flow, discharge and management of the front door to ensure good and safe flow of patients through the system and to maintain key operational targets, particularly A and E four hour wait.**	***All previous progress held on paper by the Quality Department - Risk Register section*** Sep 10: The Trust delivered a strong performance against all targets at year end 09/10 and has now shown the ability to deliver most targets on a sustainable basis. However this will required continued effort. **Dec 10: Continued focus on key actions through daily capacity meetings and weekly review of key work plans and objectives on discharge and length of stay. A review of the present situation has resulted in the risk being raised from Medium to High.**	4	MED	Executive Director: Valerie Howell Lead Manager: Valerie Howell
1024	Loss of income due to application of 'non elective cap'	Under the standard 2010/11 PCT contracts, the value of emergency admissions over a 2008/9 threshold is reimbursed at a 30% marginal rate. Growth in non elective admissions will generate more costs than income and may prevent the Trust meeting its financial targets	12	HIGH	23-Jun-2010	2-Feb-2011	Action plans are in place to manage non elective admissions. These are being overseen by Programme 2 'Improving service productivity and quality' **Dec 10: Action plan being reviewed and updated as we monitor the impact of winter on our performance. Refer to progress for the latest aspects of this.**	***All previous progress held on paper by the Quality Department - Risk Register section*** Oct 10: An updated action plan was submitted to the September meeting of the Finance Sub Committee. **Dec 10: Changes underway in A and E and Specialist Assessment Pathways. Implementing attendance avoidance pilot and further work underway for Ambulatory Care Pathways.**	3	LOW	Executive Director: Valerie Howell Lead Manager: Karen Lillington

Corporate Risk Register as at 2nd December 2010

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
1088	Possible non-compliance with IG Toolkit submission and achievement of Level 2 on all requirements	Version 8 of the toolkit states that all requirements now need to be scored at Level 2 or higher in order for the assessment to be satisfactory. Failure of any one requirement will result in an unsatisfactory result and could impact on the SOC held by the Trust. Particular concern is around the requirement of IG training and that 95% of all staff have to complete the online training. Risk of financial loss, failure to meet National targets and statutory duty.	12	HIGH	12-Oct-2010	5-Jan-2011	Action plan currently being drawn up by IG manager in order to identify gaps and to nominate leads on each requirement **Nov 10: Awareness sessions to be run where requested by departments Briefing paper to be prepared for all staff on mandatory IG training.**	**Nov 10: Staff briefing paper being developed by the IG manager.**		LOW	Executive Director: John Headley Lead Manager: Tracy Street

Corporate Risk Register as at 2nd December 2010

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
1089	Lack of outpatients receptionist staff in the Trust.	This is a Risk to: compliance with PbyR and RTT data quality standards,the Trust's reputation as a result of a poor outcome of Picker Outpatient Survey Report, increased staff sickness levels, continued reliance on Bank and Agency staff. Current established staffing is at a ratio of 250-290 patients per receptionist (depending on site and week day). In addition, no uplift is in place to allow for sickness or annual leave, leaving remaining staff carrying an additional burden of patients to process through outpatient reception. Recommended staffing ratios should be around 70-100 patients per receptionist. More detail is shown in the original paper copy of the Notification Form.	12	HIGH	12-Oct-2010	2-Feb-2011	**A Business Case is to be submitted to provide adequate staffing levels. Nov 10: Agency/Bank being used to cover on short term basis whilst Equip Rapid Improvement Event planned for December/January to identify best practice and apply lean principles. Merge of Front of House Reception and Outpatient Reception to be considered. Business case for electronic self-check-in service to free up Reception staff being drafted. Once RIE completed, appropriate establishment will have been identified and recruitment take place if required. Improved training of existing staff to enable them to flex across different sites and specialties.**	**Nov 10: Sickness Capability management of two full time staff currently on long term sick: Occupational Health referrals completed. Keep in touch meetings planned for w/b 29.11.10.**		LOW	Executive Director: Valerie Howell Lead manager: Hannah Donoghue (Patient Access)

Corporate Risk Register as at 2nd December 2010

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
1072	Discharge process has identified risks to vulnerable patients	Cause for concerns relating to poor discharge planning Discharge themes identified through complaints and PALS analysis	9	HIGH	2-Sep-2010	3-Jan-2011	1. Review Discharge Policy 2. Multidisciplinary team meetings to expedite discharge plans 3. Estimated date of discharge to be agreed and adjusted according to patients medical, functional and cognitive needs 4. Development of a seamless patient pathway for elderly complex discharges 5. Develop training for ward sister 6. Communication , using the daily white boards, auditing of the use of the discharge check list 7. More responsive nurse handover promoting nurses handover at the bedside 8. Maintain continuity of care by Medical staff 9. Managing expectations of family and carers working in partnership. 10. End of Life Care pathway 11. Discharge prior to holiday period 12. Winterplanning and capacity 13. Readmissions identified	**Nov 10:Project team set up and actions in progress, risk matrix in development. Inputting to Sisters meetings and part of the planned Sister development programme. Nursing workforce review in consultation to strengthen the Divisional Nursing structure. EDD against actual and gap analysis is being discussed. New nursing documentation of the SAP launch 22nd November.**		LOW	Executive Lead: Susan Osborne Lead Manager: Vanessa Avlonitis cc Claire O'Brien

Corporate Risk Register as at 2nd December 2010

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
768	Staff recruitment and retention. (BAF 2.2)	Failure to recruit and retain sufficient numbers of skilled and experienced clinical staff resulting in a risk of inadequate staffing with a consequent impact on the quality of patient care.	9	HIGH	12-Mar-2008	2-Feb-2011	***Previous Action Plan/s held on paper in the Quality Department - Risk Register section.*** **Dec 10: (update of Oct 10 plan) -** **1. Continued implementation of Nursing R&R Strategy/action plan includes rolling, generic recruitment for band 5 nurses.** **2. Continuation of ONP course, ending in February (16 participants).** **3. Implementation of nursing workforce review to inform future recruitment plans** **4. Recruitment of A&E doctors & implementation of new middle grade A&E rota. 5. Reduction in Midwifery vacancy rate since August (26 to 23%) continues to be supported through dedicated action plan, includes recruitment in Ireland and UK universities, jobs fairs etc. Fortnightly Maternity R&R meeting.**	***Previous progress held on paper in the Quality Department - Risk Register section.*** **Dec 10: [1]. Sustained downward trend in nurse vacancies (qualified vacancies down from 16.2% in April to 11.8% in October). Net qualified Nurse & Midwife headcount has increased by 21 since April. 12 new Band 5 staff nurses being processed for medical wards. All vacancies in A&E nursing establishment have been filled. [2]. ONP course commenced in September. 16 nurses on track to register with NMC in Feb. [3]. A&E middle grade job descriptions reviewed and shortlisting of applicants taking place. 1 consultant to commence in Feb. Locum Consultant advert currently open. [4]. Midwifery R&R plan agreed and being implemented. Maternity vacancies reduced from 33 wte (bands 5 - 7) to 28 wte. 10 more midwives appointed to commence between Dec and Apr with a further 7 applicants being considered.**	4	MED	Executive Director: Raj Bhamber Lead Manager: Jeremy Over cc Raj Bhamber
832	Loss of income-Contracts. (BAF 3.4)	There is a loss of income related to DH-mandated financial penalties, for non-achievement of key performance targets, including single-sex accomodation	8	HIGH	26-Mar-2009	5-Jan-2011	***Previous Action Plan/s held on paper in the Quality department - Risk Register section.*** Sep 10: Develop transparent process for devolving financial targets for CQUIN performance to divisions. **Nov 10: Report being developed with Information dept to assist Divisions in auditing any potential LPP activity.**	***All previous progress held on paper in the Quality department - Risk Register section.*** Sept 10: Methodology for devolving CQUIN income to divisions developed. Expected to be reported through new format monthly performance reports from October 2010. **Nov 10: Reporting on CQUIN to Board via Finance report. Clinical Divisions still finalising the format of their monthly dashboards, but CQUIN information already available at Divisional level and shared with GMs.**	6	MED	Executive Director: John Headley Lead Manager: Sue Robertson

Corporate Risk Register as at 2nd December 2010

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
847	Under delivery of CIP programme. (BAF 4.4) - Financial risk	There is under delivery of the Cost Improvement Plan (CIP). In particular the reduction in additional active work, for example Saturday lists and external referrals. This is a financial risk to the Trust.	8	HIGH	20-May-2009	2-Feb-2011	***Previous Action Plan/s held on paper in the Quality department - Risk Register section.*** **Aug 10: Revaluation of all existing schemes. Increased governance arrangements around all schemes. Weekly update to CEO. Weekly update on schemes progress by General Managers. Re-launch of CIP programme. Additional schemes identified.**	***Previous progress held on paper by the Quality Department - Risk Register section.*** Oct 10: The CIP Programme manager is working with divisional managers and other budget holders to identify new schemes and to close the gap. Month 5 gap was reduced and month 6 is forecast to have further reduction. **Nov 10: Instigation of CIP sign off meetings at Month close. Development of risks and opportunities schedule. Risk score lowered from 12 to 8 but remains a high risk.**	2	LOW	Executive Director: John Headley Lead Manager: Rob Jeffries

Corporate Risk Register as at 2nd December 2010

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837	Delay in Psychiatric assessment - A & E and MAU	Due to a change in the service the home treatment team (HTT) provide assessment of psychiatric referrals in A & E. The current service has been placed at a lower priority . There is restricted out of hours service. This results in delays in acute psychiatric assessments. At risk: Patients, staff and service. (4hr target)	6	MED	9-Apr-2009	2-Mar-2011	***Previous Action Plan/s held on paper in the Quality department*** Aug 10: 1. Develop one-page overview of which psychiatric services to contact under what circumstances - Nasreen Moosafur, 31 August (Lead, Liaison Psychiatric Team) 2. Write-up issues arising related to psychiatric patients in the A&E and email to Lucy O'Meara - A&E, ongoing (6+ forms have submitted to date) 3. Implement monthly Local Mental Health Interface meetings - Nasreen Moosafur, Kate Lawrence, Wendy Daniels (complete - first meeting scheduled for 9 Sept) 4. Increase the number of psychiatric nurses as part of the Liaison Psychiatry team from 1 to 3 and increase cover from 5 pm up until 8 pm - Lucy O'Meara, 31 July (delayed due to consultation process) 5. Consider commissioning of 3 PAs per week of Consultant Psychiatric time - Claire O'Brien/Pat Rubin 6. Develop joint care plans for top re-attenders to A&E - Nasreen Moosafur & Wendy Daniels, 30 Sept and ongoing 7. Develop a joint plan for improving care of patients presenting at A&E with psychiatric issues - N Moosafur, W Daniels and L Stanna	***All previous updates held on paper by the Quality department - Risk Register section*** Aug 10: New action plan. Less breaches; psychiatric referrals reducing and a good dialogue with the Psychiatric liaison service. Risk reduced from High to Medium (Pat Rubin) **Nov 10: Monthly Interface meetings now in place - Kate Lawrence's name to be replaced by Charlotte Freeman. Claire O'Brien has commissioned additional psychiatric assessments of Consultant time from 1st Dec. Additional meeting to be held with A&E and Brian Parsons to agree way forward on 17th November.**	2	LOW	Executive Director: Valerie Howell Lead Manager: Pat Rubin Contact: Pat Rubin

Corporate Risk Register as at 2nd December 2010

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
833	Loss of private service provider	Possible loss of provision of services vital to running trust services delivered through partnerships with private providers namely Alliance and Inhealth.	6	MED	26-Mar-2009	2-Jan-2011	1. Re-negotiation of contract for a 10 year period with Alliance. 2. Negotiate a contract extension for 18 months with Inhealth. 3. Joint management boards to review quarterly.	***All previous progress held on paper by the Quality Department - Risk Register section.*** June 10: Finance committee has agreed to extend the contract for another 12 months while a full tender process is actioned. Oct 10: No change. **Dec 10: Undergoing a review of the action plan and progress by the new lead manager (KL).**		LOW	Executive Director: Valerie Howell Lead Manager: Karen Lillington
1037	Failure to monitor and review compliance with CQC regulations.	New documentation from CQC is ongoing as CQC establish approach and changes may occur due to new government. Compliance with regulations is prospective and the Trust must develop an approach which demonstrates we are able to identify and respond to gaps quickly, with a focus on delivery of outcomes as well as process.	6	MED	16-Jul-2010	2-Jan-2011	July 10: Process for review continues to be via small teams related to standard and executive sponsor and utilising performance accelerator to provide risk rating for prompts and overall compliance rating. Full review of all essential standards being undertaken in Q1, identifying any gaps and actions, executive review during July and report to IGAC in August. Directorates are providing assurance against standards at CGC; this is to provide local outcome review. Regular communication with assessor to ensure we are up to date with our understanding of requirements. **Oct 10: Link in with committees to good understanding of requirements to oversee relevant outcomes.**	Sep 10: Q1 review behind schedule; majority of standards reviewed, but two outstanding. Delays in uploading information. Actions taken include ensuring 1/2 day set aside for Head of Quality & IG and Deputy Chief Nurse to meet and review outstanding. Plan to be on track for Q2 review, with all evidence uploaded. To report back to Executives if this plan appears to be going on track. **Oct 10: QRP (risk rating) from CQC received with no red risk areas. Ongoing monitoring of standards in place. Risk reduced from High to Medium.**		LOW	Executive Director: Lead Manager: Sarah Johnston

Corporate Risk Register as at 2nd December 2010

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
1057	Possible loss of patient confidence in the Complaints service.	The Trust is working to devolve responsibility for the drafting of complaint responses to Divisions. Complaints management is governed by Legislation, CQC and NHSLA standards. Also monitored by PHSO. There is a need to adhere to governance standards and continue to maintain high standards in complaints management while ensuring a high quality response. Risk to Trust reputation and failure of statutory duty	6	MED	12-Aug-2010	8-Mar-2011	1. Resource library on T drive including guidance notes and 'top tips'. 2. Clarity of expectation and performance standards with associated monitoring (via Customer Affairs and Performance meetings). 3. Training with Directorates as required. 4. Continued process of qualitative assurance. (Complaints Manger, Head of Customer Affairs, Chief Nurse). 5. Complaints Office support within Divisions. 6. Ongoing discussion with General Managers re implementation. **Nov 10: Review at the next CMG meeting in February 2010.**	**Nov 10: The risk and action plan were fully discussed at the Complaints Monitoring Group on 5 Nov where it was agreed the risk remain unchanged. The action plan will be monitored and reviewed at the next meeting on 4 February 2011.**		LOW	Executive Director: Susan Osborne (Acting Chief Nurse) Lead Manager: Jill Down (Head of Customer Affairs)
1083	Corporate lack of Trust Social Services worker post	Currently there is no designated social services worker to lead on safeguarding children by the local authority. The risk is that vulnerable children could be missed or become unsupported by the lack of continuity of a designated social worker identified for the Trust. This risk applies to wherever children are cared for within the Trust, specifically Paediatric A&E, Paediatric wards and Paediatric Outpatients. Risk to patients, service,reputation and failure of statutory duty.	6	MED	21-Sep-2010	2-Jan-2011	The risk has been on the Children's Services Risk Register since December 2009. Since which time steps have been taken, including the naming of a link social worker and updating of processes in A&E, however the risk still persists. Following escalation, our Chief Executive wrote to the Chief Executive of Surrey County Council to arrange a meeting. Since which time our Chief Executive has spoken on the telephone with Andy Roberts, Strategic Director for Children, Schools and Families who has agreed to do a fast review of the situation.	**Nov 10: Mitigation arrangements put in place including strengthening of link Social services worker, now confirmed as from Assessment Team. Strategy meetings to take place on SPH site where child is an inpatient. Ongoing monitoring of the situation ie low threshold for reporting of adverse incident which occur as a result of the lack of SW. Risk reduced from High to Medium (MH)**		LOW	Executive Director: Susan Osborne Lead: Helen Sibley, Nikki Love, Dr Kate Brocklesby Contact: Michael Hooker

Corporate Risk Register as at 2nd December 2010

ID	Title	Description	Rating	Risk level	Opened	Review date	Action Plan Details	Progress	Rating (Target)	Risk level (Target)	Responsibility Owners
769	Disproportionate focus on post Foundation Trust authorisation tasks.	The Foundation Trust application has significant potential to divert Executive and Clinical Directors from achieving our ASPH organisational objectives.	4	MED	12-Mar-2008	5-Mar-2011	***Previous Action Plan/s held on paper by the Quality Department - Risk Register section.*** July 10: The Foundation Trust application (strategic objectives in the IBP) & Corporate Plan (annual objectives) are aligned. A dedicated Project Manager is coordinating the FTA through the FT Board. Sep 10: No change to the action plan	***Previous progress held on paper by the Quality Department - Risk Register section.*** Sep 10: No additions to progress. Risk title changed from 'Failure to achieve Foundation Trust status' **Nov 10: The risk has changed to 'Disproportionate focus on post FT authorisation tasks'. The risk will be managed by identified resources in the dedicated membership office and the Communications Team to plan and implement post authorisation tasks.**	3	LOW	Executive Director: Raj Bhamber Lead Manager: Raj Bhamber, Vicki Hart-Dale
766	Patient satisfaction scores. (BAF 1.7)	Potential failure to improve our patient satisfaction scores at national patient surveys (In patient / A & E / OPD)	4	MED	12-Mar-2008	2-May-2011	***Previous Action Plan/s held by the Quality Department - Risk Register section*** . **Dec 10: 1. Patient information subgroup formed 2. Patient Access subgroup formed 3. Identify top three trends from 'your' feedback 4. Triangulating data from 'Your' Feedback 5. Discharge planning group with matrix. 6. Focus on End of Life Care. 7. Incentivisation of staff. 8. Relaunch the Patient Experience indicators.**	***All previous progress held on paper by the Quality Department - Risk Register section.*** Sept 10: Dignity gowns are now being trialled. Ward Quality indicators are in place. Noise at night has progressed but remains an issue for some patients. The patient comment card is providing weekly feedback. **Dec 10: This is work in progress and will be monitored through the Programme Board.**	6	LOW	Executive Director: Susan Osborne Lead Manager: Vanessa Avlonitis, Jill Down

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767	Privacy and Dignity issues for service users. (BAF 1.8)	Potential failure to improve upon Privacy and Dignity issues for service users resulting in possible patient anxiety and risk to Trust reputation	3	LOW	12-Mar-2008	2-May-2011	Require strict adherence to the reduction and ultimate elimination of the acceptance of mixed sex gender accommodation for patients in all general areas and improved awareness and action to minimise the impact on patients in assessment and high intensity care arenas. Aug 10: Refurbishment ongoing. **Nov 10: Needs to be kept on the risk register due to capacity pressures although currently compliant and refurbishment almost complete.**	***Previous progress held in the Quality Department - Risk Register section*** Aug 10: Peer review very positive. No single sex breaches apart from Clinical need. Work continues to ensure compliance with the single sex accomodation agenda. Risk reduced from Medium to Low. **Nov 2010: No change except that Kestral has opened. Plans to address Privacy and Dignity for the older person in January 2011.**	4	LOW	Executive Directors: Susan Osborne Lead Manager: Vanessa Avlonitis
988	VTE phrophylaxsis assessment shortfall	The Trust is expected to demonstrate a 100% compliance with Venous Thromboembolism (VTE) [blood clot] risk assessment by April 2010. Currently (25/02/10) the Trust is achieving 61%. This will be a nationally and locally scrutinised target. Risk to patient safety, financial loss and reputation.	2	LOW	25-Feb-2010	5-Mar-2011	***Previous Action Plan/s held by the Quality Department - Risk Register section.*** June 10: 1. VTE monitoring to be performed weekly, to supply national and CQUIN information. 2. VTE compliance is to be on all directorate performance dashboards and reviewed at monthly performance meetings.	***Previous progress held in the Quality Department - Risk Register section*** **Nov 10: Trust now compliant at 90%. SHA has identified ASPH as an exemplar site. RCA for all admissions with PE and DUT now in place. Monthly audits of VTE assessment quality with PE and DUT now in place. Monthly audits of VTE assessment quality to be commenced December 2010. Risk reduced from medium to low.**		LOW	Executive Director: Mike Baxter Lead Manager: Mike Baxter

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Tolerate: Accept the risk at its current level of risk.											
1070	NHS funded healthcare team not completing patient assessments in the Trust which is impacting on capacity.	***Precis of description*** The unusually large amount of delayed discharges is now having a big impact on capacity within The Trust. This number increases every day. This morning 4 more patients will be added to this number. The impact of the above number means that The Trust's ability to maintain capacity flow, 4 hour waits & 18 week targets are very much reduced. The NHS Funded healthcare team have been asked by Claire O'Brien whether they would be prepared to second one of their nurse assessors to assist the Senior Discharge Co-coordinator to train ward staff to undertake some of the assessments. The NHS funded Healthcare team has confirmed this is not possible. Risk to patients, service, finances, not meeting targets and Trust reputation.	6	MED	31-Aug-2010	2-Jan-2011	1. Claire O'Brien - Head of Capacity & Discharge has discussed this issue at executive level both within The Trust and with The NHS Funded Healthcare Team. 2. The NHS Funded Healthcare Team need to consider recruiting to the vacant posts they have but it is unsure whether they have the ability/funding to do this. 3. Consider increasing The Discharge Team - it would be possible to take control and complete the assessments if this was considered. This would greatly assist and speed up the process. **Oct 10: Plan to use RN 4 days per week to support MDT training for NHS funded care checklists and Decision Support tool (DST) assessments**	**Oct 10: Current discharge team have managed to get through current back-log however demand continues; additional bank resource and recruitment of new staff to discharge team will support management of demand. Risk reduced from High to Medium and Tolerated. (Claire O'Brien)**		LOW	Executive Director: Valerie Howell Lead Manager: Claire O'Brien cc Juliet Rayner